ACT Government | Canberra Health Services

# Canberra Health Services
# Consultation Paper

## Proposal for Emergency, Flow and Access Unit

Office of the Chief Operating Officer

August 2022

| Work Area | Author(s) | Contact Details |
|---|---|---|
| Office of the COO | Cathie O'Neill | CHSCOO@act.gov.au |

# Contents

# 1. Introduction

Canberra Health Services (CHS) is focussed on the delivery of high quality, effective, person centred care. It provides acute, sub-acute, primary and community-based health services to the Australian Capital Territory (ACT)—a catchment area of approximately 400,000 people. It also services the surrounding Southern New South Wales region which includes the Bega Valley, Bombala, Cooma-Monaro, Eurobodalla, Goulburn, Mulwaree, Palerang, Queanbeyan, Snowy River, Upper Lachlan Shire and the Yass Valley.

CHS administers a range of publicly funded health facilities, programs and services.

CHS is a partner in teaching with the Australian National University, the University of Canberra and the Australian Catholic University.

To enable CHS to have a strong focus on operational effectiveness, efficiency and accountability in the health services we provide, CHS is proposing a realignment of functions.

There are a number of drivers behind this proposal:

- The Division of Medicine (DoM) is very large with multiple specialties;
- The attainment of Key Performance Indicators (KPIs) in the Emergency Department (ED) is highly variable and performance is regularly below target;
- Bed block has a significant impact on the ED's ability to manage flow through their unit with limited ability to impact bed capacity in ward areas;
- Patient Flow is the engine room of the movement of patients through the whole system but has lacked structure, resourcing and gravitas to undertake its work effectively;
- After hours management of patient flow is problematic (this was subject to a separate consultation paper which has resulted in the move towards a 24 hour coordination hub which is now under development);
- Non-admitted flow and direct admissions is not as visible as that through the ED; and
- Insufficient focus is applied to the management of those referred for specialist outpatient care, including ensuring adequate management plans and escalation points are in place. This is evidenced by an average of 27 presentations per day - from people on the Ambulatory Care Waitlist for an initial appointment, equating to about 9,800 presentations per year. Whilst not all presentations will be for the condition for which they have been referred, it does lean to an issue which needs to be addressed systemically.

## 2. Proposal

This paper seeks feedback on the merits of a proposal to create an Emergency, Access and Flow Unit (the Unit) reporting directly to the Chief Operating Officer (COO).

This Unit would bring together the functions of the:

- Emergency Department
- Patient Flow (and the Coordination Hub once formed); and
- Central Health Intake (CHI).

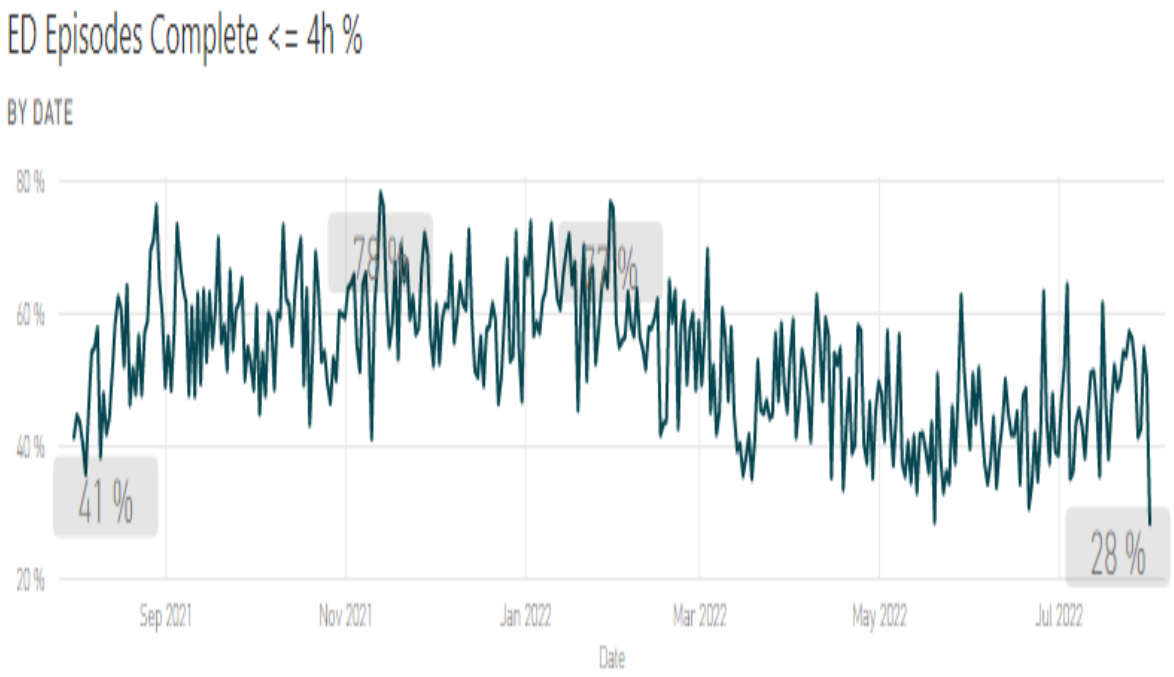
## 3. Current model

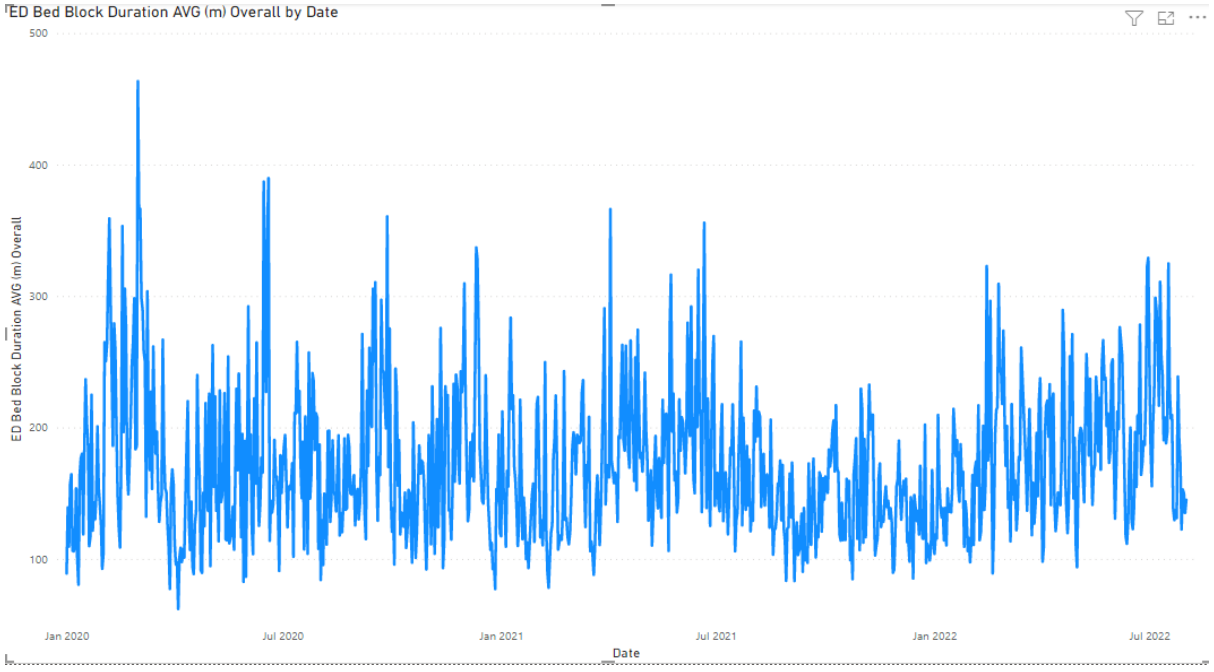
Currently, these three units report to different divisions with different governance structures and priorities.

## 4. Rationale for change

Patient flow and ED management are both complex environments with multiple factors influencing outcomes. Many of these factors are outside the control of individual units. Quality improvement theory notes that variation is a sign of systems out of control, and usually as a result of 'waste' in the system due to ineffective, poorly defined processes. The following graphs show National Emergency Access Target (NEAT) and Bed Block (minutes) and both show significant variability.

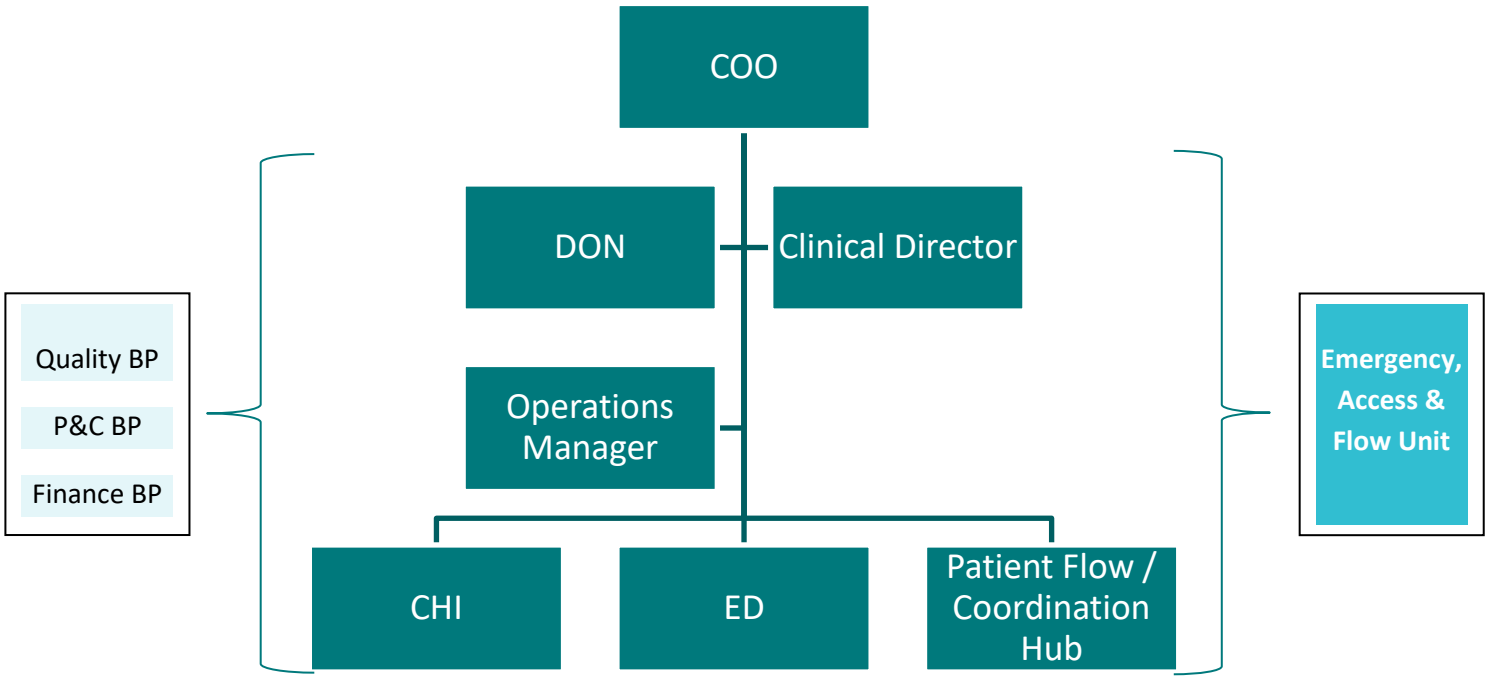
This indicates that taking a systems approach with process improvement should reduce the variability and would likely improve overall performance. To help achieve that improvement an integrated, collaborative approach and governance structure to the major units contributing to flow should assist.


ED Episodes Complete <= 4h %
BY DATE
80 %
60 %
40 %
20 %
41 %
28 %
Sep 2021
Nov 2021
Jan 2022
Mar 2022
May 2022
Jul 2022
Date


ED Bed Block Duration AVG (m) Overall by Date
500
400
300
200
100
ED Bed Block Duration AVG (m) Overall
Jan 2020
Jul 2020
Jan 2021
Jul 2021
Jan 2022
Jul 2022
Date

# 5. Future model

## 5.1. Scope of the future model




Reporting lines within each Unit are not intended to change. The roles of the Director of Nursing (DON) of Patient Flow, Operations Manager (Patient Flow) and the Clinical Director for Emergency Department will be expanded to oversight the whole Unit. If the proposal achieves widespread support for progression further work will be undertaken to specify the organisational chart bringing together the three units in consultation with position holders.

## 5.2. Benefits of the future model

Anticipated benefits include:

- Integrated governance of the major patient flow units;
- A stronger engagement across the patient continuum through the inclusion of non-admitted flow;
- Cost neutral structural change;
- Reduction in bed block,
- Coordinated oversight of demand and capacity;
- Organisational wide approach rather than divisionally siloed, including to the attainment of KPI for NEAT, bed block and Relative Stay Index (RSI)
- Reduce the size of the Division of Medicine;

- Increase the role, function and influence of the Patient Flow and After-Hours Hospital Managers; and
- Improve efficiency prior to the opening of the Critical Services Building to ensure new models of care are optimised.

## 5.3. Implementation of the future model

Implementation would involve:

- Movement of reporting lines of the respective units named. This would automatically move the reporting within units to the new unit but would not involve any restructure per se (noting that other drivers may result in specific unit changes, but these would be subject to different consultation processes);
- Review of position descriptions for the Director of Nursing Patient Flow, Clinical Director Emergency Department and Operations Manager Patient Flow. This may result in minor changes to allowances or grading;
- Review of allocation of business partners to ensure appropriate coverage; and
- Re-allocation of relevant priorities, actions and strategic actions from DoM and Cancer and Ambulatory Services to COO for relevant items.

## 5.4. Related change processes

If agreed, the relevant changes will be made to the following:

- Organisational chart
- Cost centres
- Budget / FTE

## 5.5. Implications for not undertaking the change

This is a genuine consultation – if feedback suggests that this change is not going to achieve the desired outcomes, particularly if alternates are proposed, then the change will not proceed.

# 6. Consultation methodology

Feedback can be provided via email to CHSCOO@act.gov.au by COB 2 September 2022**.**

**In particular we are seeking responses to the following questions:**

1. What do you see as the merits of this proposal?
2. Do you think the changes will drive the stipulated benefits? Are there other benefits?
3. Are there any unintended consequences of this proposed change? What are they?
4. What else should be considered prior to making this change?
5. Do you have a suggestion for the Units' name – particularly if it has a better acronym?
6. Do you have any particular concerns regarding this proposal?

If you would like to provide feedback in person, or have the COO come to a team meeting to do a Question and Answer session, please contact the COO Office 5124 5804 or via email at CHSCOO@act.gov.au.